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Breffni Care Centre, Ballyconnell, Cavan.

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**Health Information and Quality Authority
Regulation Directorate**

**Compliance Monitoring Inspection report
Designated Centres under Health Act 2007,
as amended**



Centre name:	Breffni Care Centre
Centre ID:	OSV-0000489
Centre address:	Ballyconnell, Cavan.
Telephone number:	049 952 6782
Email address:	ann.gaffney@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Rose Mooney
Lead inspector:	PJ Wynne
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	20
Number of vacancies on the date of inspection:	2

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- to carry out thematic inspections in respect of specific outcomes
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration renewal decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
18 March 2015 09:00	18 March 2015 17:30
19 March 2015 09:10	19 March 2015 16:15

The table below sets out the outcomes that were inspected against on this inspection.

Outcome 01: Statement of Purpose
Outcome 02: Governance and Management
Outcome 03: Information for residents
Outcome 04: Suitable Person in Charge
Outcome 05: Documentation to be kept at a designated centre
Outcome 06: Absence of the Person in charge
Outcome 07: Safeguarding and Safety
Outcome 08: Health and Safety and Risk Management
Outcome 09: Medication Management
Outcome 10: Notification of Incidents
Outcome 11: Health and Social Care Needs
Outcome 12: Safe and Suitable Premises
Outcome 13: Complaints procedures
Outcome 14: End of Life Care
Outcome 15: Food and Nutrition
Outcome 16: Residents' Rights, Dignity and Consultation
Outcome 17: Residents' clothing and personal property and possessions
Outcome 18: Suitable Staffing

Summary of findings from this inspection

This report set out the findings of an announced registration renewal inspection, which took place following an application to the Health Information and Quality Authority (the Authority) Regulation Directorate, to renew registration of the designated centre.

The inspector met with the person in charge and staff team who all displayed a good knowledge of the Authority's Standards and regulatory requirements and were found to be committed to providing quality person-centred care to the residents.

The inspector found that the residents were well cared for and that their nursing and

care needs were being met. Residents had good access to general practitioners (GP). The person in charge was fully involved in the management of the centre and was found to be easily accessible to residents, relatives and staff.

There was evidence of individual residents' needs being met and the staff supported residents to maintain their independence where possible. There was a variety of social and recreational activities led by a full time activities coordinator.

Some improvements were identified to further enhance the service provided. Further work is required in exploring alternative options to promote a restraint free environment in line with national policy. Care plans for residents with dementia or cognitive impairment and behaviours that challenge required review to ensure they are more person centred.

There are four bedrooms accommodating four residents each. The provider at the time of this inspection did not have in place a plan to reconfigure multiple occupancy bedroom accommodation. This is required in accordance with the premises and physical environment regulatory notice and the National Quality Standards for Residential Care settings for Older People in Ireland.

The action plan at the end of this report identifies these and other areas where improvements must be made to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Outcome 01: Statement of Purpose

There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:

Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

The statement of purpose set out the services and facilities provided in the designated centre and the majority of the requirements of Schedule 1 of the Regulations. The statement of purpose is kept under review by the provider.

Judgment:

Compliant

Outcome 02: Governance and Management

The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:

Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

There was a management structure in place to ensure the effective governance of the service. The inspector found that the management structure was appropriate to the size, ethos, purpose and function of the centre.

Roles and responsibilities were defined and implemented in the centre in terms of

oversight of the delivery of care. The HSE had appointed a person to the role of provider nominee who was suitably qualified and experienced to carry out the functions of the post. There were adequate resources available including staffing, management structures and equipment.

There was evidence of quality improvement strategies and monitoring of the services. The inspector reviewed audits completed by the person in charge and the clinical nurse manager. A system of audits is planned on an annual basis to include medication management, any accident/falls sustained by residents and care planning. The inspector found that this information was used to improve the service.

However, monitoring systems require further development by the provider to ensure a more robust approach in line with the requirements of regulation 23. Annual reviews of the quality and safety of care were not undertaken by the provider. They were not completed in consultation with the residents and their families and copies of reports made available to residents. However, the data collected will help provide the necessary information.

Judgment:
Substantially Compliant

Outcome 03: Information for residents
A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

Theme:
Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
There was an information display area with relevant brochures to provide age appropriate information to residents in relation to health promotion, protection and finances.

There is a residents' guide available containing the information required by the Regulations. However, the residents' guide was not readily available to residents or their families. It was not included with all the other brochures on the information stand in the lobby.

The inspector reviewed a sample of three contracts of care to include the contract for the residents mostly recently admitted to the centre. All contracts were signed by relevant parties. The inspector found that each resident had an agreed written contract which included details of the services to be provided for that resident and the fees payable by the resident.

Judgment:
Substantially Compliant

Outcome 04: Suitable Person in Charge
The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The person in charge has not changed since the last inspection. She is a registered nurse and holds a full-time post. She was well known by residents. She had good knowledge of residents care needs and could describe in an informed way where residents had specific needs and how staff ensured that their care needs were met appropriately.

During the inspection the person in charge demonstrated good knowledge of the legislation and of her statutory responsibilities. Records confirmed that she was committed to her own professional development.

She had attended mandatory training required by the Regulations. She has attended training courses in nutrition in the elderly, end of life care, dementia care and infection control.

Judgment:
Compliant

Outcome 05: Documentation to be kept at a designated centre
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:
Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

The inspector found that there were systems in place to maintain complete and accurate records. Records were stored securely and easily retrievable.

Written operational policies, which were centre specific, were in place to inform practice and provide guidance to staff.

The inspector found that medical records and other records, relating to residents and staff, were maintained in a secure manner. Appropriate insurance cover was in place with regard to accidents and incidents, out sourced providers and residents' personal property.

The directory of residents contained the facility to record all the information required by schedule three of the regulations. The inspector reviewed the electronic directory and noted all the information was maintained except the details of the cause of death when established.

A sample of four staff files were examined to assess the documentation available, in respect of persons employed. All the information required by Schedule 2 of the Regulations was available in the staff files reviewed.

Judgment:

Substantially Compliant

Outcome 06: Absence of the Person in charge

The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:

Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

The provider was aware of the requirement to notify the Chief Inspector of the proposed absence of the person in charge for a continuous period of 28 days. The clinical nurse manager, grade two is the key senior manger appointed to deputise while the person in charge is absent.

Judgment:

Compliant

Outcome 07: Safeguarding and Safety

Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:

Safe care and support

Outstanding requirement(s) from previous inspection(s):

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

The inspector was provided with a copy of the centre's policy on prevention, detection and response to elder abuse. The policy was specific to the centre and defined the various types and signs of abuse and the reporting arrangements. Protected disclosure procedures to guide staff in their reporting of a suspicion of abuse were documented in the policy.

Residents informed the inspector that they felt safe and very well cared for in the centre by all staff. This was confirmed by relatives in questionnaires submitted to the Authority. There was a visitors log in place and the entrance door was monitored by CCTV. The unrestricted access to the residential part of the building was reviewed and access doors were fitted with coded key pads. No incidents, allegations or suspicions of abuse have been recorded or notified to the Authority in the preceding 12 months at this centre.

Staff to whom the inspector spoke with were able to confirm their understanding of the features of protection of vulnerable adults and to whom they would report a concern. All staff had up to date refresher training in protection of vulnerable adults. This training was ongoing, facilitated by a suitably qualified professional with experience in this area.

The financial controls in place to ensure the safeguarding of residents' finances were examined by the inspector. There was a policy outlining procedures to guide staff on the management of residents' personal property and possessions. A petty cash system was in place to manage amounts of personal money for residents. A record of the handling of money was maintained for each transaction. Two signatures were recorded for each transaction. The ongoing balance was transparently managed.

There is a policy on the management of behaviour that is challenging and supportive strategies were in place. Psychotropic medications used were pertinent to specific behaviours. These were closely monitored by the prescribing clinician and regularly reviewed to ensure optimum therapeutic values.

There was a policy on restraint management (the use of bed rails and lap belts) in place. The number of residents with two bed rails raised has decreased since the last

inspection. At the time of this inspection seven residents had two bed rails in use. Six new ultra low beds have been obtained which has assisted in promoting a restraint free environment. Restraint risk assessments were revised routinely. The rationale for each bed rail was outlined in the risk assessment documentation reviewed. However, further work is required in exploring alternative options prior to using a restraint measures to promote a restraint free environment in line with the national policy.

Staff spoken with were very familiar with resident's behaviours and could describe particular residents daily routines very well to the inspector. However, all staff had not received training in behaviours that challenge to ensure they have up to date knowledge and skills to respond appropriately. This is planned by the person in charge for 2015.

Judgment:
Substantially Compliant

Outcome 08: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Safe care and support

Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
The inspector found that the health and safety of residents, staff and visitors in the centre was promoted and protected. The governance arrangements to manage risk situations were specified. Responsibility for health and safety procedures and an organisational safety structure was included in the risk management policy.

The actions in the previous inspection which related to risk, health and safety were satisfactorily completed. Smoking risk assessments were completed for all residents who smoke to outline the level of supervision or assistance they require.

A falls management and prevention policy was developed and implemented. The policy provides clear procedures to guide staff actions and interventions should a resident sustain a fall. The policy included clear details on completing neurological observations in line with best practice. A sample of accidents reviewed in the incident register evidenced neurological observations were being completed appropriately. This was an area identified for improvement on the last visit.

Since the last visit the centre has participated in a falls reduction project titled, 'Forever Autumn'. This has improved staff awareness and the centre has achieved the aim of the project across the service to develop a multi disciplinary approach to falls prevention and management.

There was an emergency plan and this was found to be appropriate with identification of services and emergency numbers in the event of a range of possible occurrences. A missing person's policy and procedures on incident reporting and risk escalation were in place. The risk management policy contained the procedures required by the regulation 26 and schedule 5 to guide staff.

Fire safety equipment including the fire alarm, fire extinguishers, emergency lighting and smoke detectors were provided and were serviced quarterly and annually as required. The escape routes, procedures to follow on hearing the alarm and action to take on discovering a fire were displayed around the building. The means of escape and fire extinguishers were checked weekly. However, the fire alarm was not activated apart from the quarterly service to ensure it was operational and automatic doors closers were in good working order.

The inspector reviewed the fire safety register and training records. Staff to whom the inspector spoke confirmed their attendance at fire training and gave accounts of their understanding of fire procedures in the event of an outbreak of fire. The person in charge had commenced undertaking fire drill practices. The records detailed the scenario/type of simulated practice, the time taken for staff to respond to the alarm and to evacuate. However, only one fire drill practice apart from annual fire training has been completed. Therefore, all staff have not had an opportunity to actively participate in a fire drill practice in addition to their annual training.

There were procedures in place for the prevention and control of infection. Hand gels were located around the building. Hygiene audits of the building were completed at intervals. A sufficient number of cleaning staff were employed. The building was visually clean on the day of inspection. The current cleaning methods minimised the risk of cross contamination. The inspector noted cleaning staff used separate mop heads for each bedroom, bathroom and communal areas to break the cycle of infection.

The training records showed that staff had up-to-date training in moving and handling. There was sufficient moving and handling equipment available to staff to meet residents needs. Each resident's moving and handling needs were identified and available to staff at the point of care delivery in bedrooms outlining whether a resident required the assistance of a hoist, size of sling or one or two staff members. This was an area identified for improvement in the action plan of the previous inspection.

Judgment:
Substantially Compliant

Outcome 09: Medication Management
Each resident is protected by the designated centre's policies and procedures for medication management.

Theme:
Safe care and support

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

There was a comprehensive medication management policy in place which provided guidance to staff to manage aspects of medication from ordering, prescribing, storing and administration.

The inspector reviewed a sample of drugs charts. Photographic identification was available on the drugs chart for each resident to ensure the correct identity of the resident receiving the medication and reduce the risk of medication error. The prescription sheets reviewed were legible and distinguished between regular and short term and as needed (PRN) medication. There was space to record the start and stop date for each drug.

The medication administration sheets viewed were signed by the nurse following administration of medication to the resident and recorded the name of the drug and time of administration. The drugs were administered within the prescribed timeframes. There was space to record when a medication was refused on the administration sheet.

One medication error had occurred since the last inspection. This was documented in the risk register and appropriate action was taken to respond to the incident. However, a specific medication error reporting form is not available to guide staff on capturing all relevant details of such incidents with prompts to guide in appropriate responsive action.

Medicines were being stored safely and securely in the clinic room which was secured. The temperature ranges of the medicine refrigerator was being appropriately monitored and recorded.

Medications that required strict control measures were kept in a secure cabinet which was double locked in keeping with the Misuse of Drugs (Safe Custody) Regulations. Nurses kept a register of controlled drugs. Controlled drugs were checked by two nurses at the change of each shift. The inspector checked a selection of the balances and found them to be correct.

Judgment:

Substantially Compliant

Outcome 10: Notification of Incidents

A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:

Safe care and support

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

The inspector reviewed a record of incidents/accidents that had occurred in the centre and cross referenced these with the notifications received from the centre. Quarterly notifications had been submitted to the Authority as required.

Judgment:

Compliant

Outcome 11: Health and Social Care Needs

Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

Theme:

Effective care and support

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

The centre can accommodate a maximum of 22 residents who need long-term care. There were 19 residents in the centre during the inspection. There were nine residents with maximum care needs. Four residents were assessed as highly dependent and six with medium dependency care needs. Many residents were noted to have a range of healthcare issues and the majority had more than one medical condition.

The arrangements to meet residents' assessed needs were set out in individual care plans. The inspector found a good standard of evidence-based care and appropriate medical and allied health care access. Recognised assessment tools were used to evaluate residents' progress and to assess levels of risk for deterioration, for example vulnerability to falls, dependency levels, nutritional care, the risk of developing pressure sores and cognitive functioning.

The inspector reviewed three resident's care plans in detail and certain aspects within other plans of care to include the files of residents with nutritional issues, forms of restraint in use and potential behaviours that challenge. The inspector found that all files reviewed were comprehensive. In the sample of care plans reviewed there was evidence care plans were updated at the required intervals or in a timely manner in response to a change in a resident's health condition. There was evidence of consultation with residents or their representative in all care plans reviewed of agreeing to their care plan when reviewed or updated. However, this was a signature and date and was not personalised to each resident's plan of care to reflect the individual care being delivered.

This was identified as an area for improvement on the previous inspection.

The risk assessments completed were used to develop care plans that were person-centred, individualised and described the current care to be given in the main. Care plans for residents with dementia or cognitive impairment and behaviours that challenge required review to ensure they are more person centred. Staff were observed to be tolerant and calm in supporting residents. Individual staff could be seen to use strategies such as bringing a resident to a different area. However, this was at the discretion of individual staff and not based on person-centred plans. Information such as whom the resident still recognises or what activities could still be undertaken was not evident to guide staff practice in care plans.

Residents had access to GP services and there was evidence of medical reviews very regularly and more frequently when a resident was unwell. Medical records evidenced residents were seen by a GP within a short time of being admitted to the centre. Access to allied health professionals to include speech and language therapist, dietetic service and occupational therapy was available to residents on referral.

There was a low incidence of pressure ulcers and this was monitored. Specialised supportive equipment including pressure relieving mattresses and cushions were used as preventive measures. Supportive aids were evident including walking frames and residents were individually supported to maintain their independence as their capacity allowed.

Judgment:
Substantially Compliant

Outcome 12: Safe and Suitable Premises

The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:
Effective care and support

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
The centre is a single-storey construction and was built in 2001. It is well maintained both internally and externally. It was found to be clean, comfortable and welcoming. There was a good standard of décor throughout.

There is one day sitting room which is suitable in size to meet the numbers of residents. A spacious dining room to meet residents' needs is located off the kitchen. Other facilities include an oratory and a hair salon. The inspector noted the building was comfortably warm. Hand testing indicated the temperature of hot water and radiators did not pose a risk of burns or scalds.

There were a sufficient number of toilets, baths and showers provided for use by residents. A new bath has been provided with a safety chair lift to assist residents safely access and egress the bath.

There are four single bedrooms and one twin bedroom. However, the majority of residents are accommodated in multi occupancy bedrooms. The maximum number of residents accommodated in each ward has reduced. There are four wards accommodating four residents each at the time of this inspection. Originally the maximum occupancy of each of these wards was six. However, the over bed lamps from the unused bed spaces have not been removed. Each bedroom has a toilet and wash hand basin. An overhead tracking hoist system is provided in each four bedded ward. However, the layout and configuration of the bedrooms did not assure the privacy of each resident.

Each multi occupancy bedroom opened onto a corridor linking all of the communal bedrooms, allowing visitors to move unrestricted between the sitting room and bedrooms on the last inspection. Some structural works to improve residents' privacy have been undertaken. A partition wall has been built on either side of the day sitting room to restrict access to bedrooms. This has enhanced the day sitting room by increasing its size. However, bedrooms either side of the day sitting room remain accessible to each other in addition to the entrance from the main corridor. Adequate wardrobe space was not provided for residents' clothing and personal possessions.

While mobile screens were available there are limitations in multi occupancy bedrooms to ensure adequate privacy. The provider at the time of this inspection did not have in place a plan to reconfigure multiple occupancy bedroom accommodation. This is required in accordance with the premises and physical environment regulatory notice and the National Quality Standards for Residential Care settings for Older People in Ireland.

Staff facilitates were provided with space for the storage of personal belongings. Separate toilets and showering facilities were provided for care and kitchen staff in the interest of infection control. A separate cleaning room and sluice area is available.

Since the last inspection a designated smoking room has been provided for residents who wish to smoke. A new storage area has been provided for the storage of clean commodes. This is separate from the sluice room where they were stored previously after cleaning posing a risk of possible cross infection.

Judgment:
Non Compliant - Major

Outcome 13: Complaints procedures

The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:

Person-centred care and support

Outstanding requirement(s) from previous inspection(s):

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

There was a local policy and procedure in place to ensure complaints were monitored and responded to. Formal complaint procedures and appeals details were outlined in the HSE complaints policy 'your service your say'. The local policy was revised since the last inspection.

A designated individual was nominated with overall responsibility to investigate complaints. The timeframes to respond to a complaint, investigate and respond to a complainant were outlined.

No complaints were being investigated at the time of inspection. A complaints log was in place which contained the facility to record all relevant information about complaints. This was revised since the last inspection and includes the details of the action taken to investigate and the complainants satisfaction with the outcome reached.

Judgment:

Compliant

Outcome 14: End of Life Care

Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

Theme:

Person-centred care and support

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

This outcome was the subject of a thematic inspection in September 2014 and all aspects of end of life were examined in detail during the inspection. There was one area identified for improvement from the last inspection which was reviewed during the course of this visit.

Records reviewed evidenced good input by the palliative team to monitor and ensure appropriate comfort measures for residents approaching end of life. A validated pain assessment tool was available for use. However, one resident receiving analgesia did not have a plan of care for pain management in place.

Resident's end-of-life care preferences and spiritual wishes were identified and documented in care plans. However, advance care planning regarding future healthcare interventions and personal choice in the event a resident became seriously ill and was unable to speak for themselves was not completed for all residents.

The policy of the centre is all residents are for resuscitation unless documented otherwise. A multi disciplinary approach was undertaken to include the resident where possible, their representative, the GP and the nursing team. Residents with a do not resuscitate (DNR) status in place have the DNR status regularly reviewed to assess the validity of clinical the judgement on an ongoing basis.

However, the system to record the DNR reviews requires clarity as the records were not always legible. The previous review date was crossed off on the form and a new date written alongside. This practice made it difficult to track the most recent decision making record.

Judgment:

Non Compliant - Moderate

Outcome 15: Food and Nutrition

Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.

Theme:

Person-centred care and support

Outstanding requirement(s) from previous inspection(s):

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

This outcome was the subject of a thematic inspection in September 2014 and all aspects of end of life were examined in detail during the inspection. There areas identified for improvement from the last inspection were reviewed during the course of this visit.

The instructions for foods and liquids that had to have a particular consistency to address swallowing problems were outlined in care plans for all residents and available to catering and care staff. Staff interviewed could describe the different textures and the residents who had specific requirements.

There was a choice for residents on a pureed/liquidised diet. The evening meal time menu offered options to ensure sufficient or optimum calorific intake particularly those for those on fortified diet.

Food and fluid intake records were maintained consistently for all residents who required assistance with their daily meals and drinks. There was a system developed since the last visit to ensure each resident's daily fluid goal was maintained and food intake was appropriate to allow for intervention at the earliest stage possible if issues arose.

All residents were weighed regularly. At the time of this inspection five residents required close monitoring and were being weighed weekly. There was evidence of referral to allied services and reviews by the dietician and the speech and language therapist. Care plans were revised to reflect updates following reviews by allied health specialists.

Judgment:
Compliant

Outcome 16: Residents' Rights, Dignity and Consultation
Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

Theme:
Person-centred care and support

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

There was evidence of a good communication culture amongst residents, the staff team and person in charge.

Residents were dressed well and according to their individual choice. The inspector observed staff interacting with residents in a courteous manner and addressing them by their preferred name.

Residents' civil and religious rights were respected. Residents and staff confirmed that they had been offered the opportunity to vote at each election either in house or their own locality.

Residents could practice their religious beliefs. . Mass or prayers take place on a weekly basis. A member of staff belongs to a religious order and provides pastoral support and

care to residents and their families. Residents of other religious denominations had access to ministers who visited. An oratory is available providing a quiet space for residents to facilitate meeting their spiritual needs.

Residents were able to exercise choice regarding the time they got up and were able to have breakfast at a time that suited them. During the day residents were able to move around the centre freely. There was a visitor's room to allow residents meet with visitors in private.

Residents had access to a variety of national and local newspapers and magazines to reflect their cultural interests and heritage. These were located in easily accessible areas and available to residents daily. A residents' forum was in place. Residents had access to an independent advocate who provided feedback to the person in charge.

There were opportunities for all residents to participate in activities. There was a structured program of activities in place which was facilitated by the activities coordinator, employed five days each week. The inspector spoke with the activity coordinator who confirmed the range of activities in the weekly program. The activity schedule provided for both cognitive and physical stimulation.

Judgment:
Compliant

Outcome 17: Residents' clothing and personal property and possessions
Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.

Theme:
Person-centred care and support

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The inspector reviewed a policy for the managing of residents' personal property. It provided guidance to staff on the storage and care of residents' belongings.

The centre provided the service to laundry all residents' clothes and families had the choice to take home clothes to launder if they wished. Some residents' clothing was sent to the local dry cleaners.

Each resident was provided with their own wardrobe. However, there was limited space to store an adequate amount of clothing for residents residing in the centre on a long term basis. One resident had a double wardrobe. However, all other residents had a single hospital style wardrobe. In many of the residents' wardrobes some hangers

contained multiple pieces of clothing. In some cases clothes were stored on the bottom of the wardrobe.

The system to ensure all clothes are identifiable to each resident requires review. The inspector checked items of clothing in residents' wardrobes. It was noted some clothes were stored in wardrobes not belonging to the correct resident. All clothes were not marked to identify ownership.

Judgment:

Non Compliant - Moderate

Outcome 18: Suitable Staffing

There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:

Workforce

Outstanding requirement(s) from previous inspection(s):

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

The inspector examined staff rosters, reviewed the planning of admissions and discussed with staff their roles, responsibilities and working arrangements. On the last inspection it was identified there was only two staff members available to meet residents needs, one nurse and one care assistant from 18:00 hrs. The provider has addressed this action from the previous report and approved increased staff levels to three staff until 20:00 hrs. The inspector found there was sufficient staff with the proper skills and experience to meet the assessed needs of residents at the time of this inspection taking account of the aims and objectives of the service.

The inspector viewed the staff duty rota for a three week period. The rota showed the staff complement on duty over each 24-hour period. The person in charge at all times was denoted on the rota. The staff roster detailed their position and full name. The inspector noted that the planned staff rota matched the staffing levels on duty.

There was a training matrix available which conveyed that staff had access to ongoing education and a range of training was provided. The inspector found that in addition to mandatory training required by the regulations staff had attended training on caring for residents with dementia and infection control nutritional care. Nursing staff were facilitated to engage in continuous professional development and had completed training

on end of life care, basic life support and nutritional assessment. As identified in Outcome 7, Safeguarding and Safety all staff had not received training in behaviours that challenge.

Judgment:
Compliant

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

PJ Wynne
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Breffni Care Centre
Centre ID:	OSV-0000489
Date of inspection:	18/03/2015
Date of response:	05/05/2015

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non-compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 02: Governance and Management

Theme:

Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Monitoring systems require further development by the provider to ensure a more robust approach in line with the requirements of regulation 23.

Action Required:

Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively

¹ The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

monitored.

Please state the actions you have taken or are planning to take:

The Registered Provider will put in place a management system to ensure that the service provided is safe, appropriate, consistent and effective. This will involve management undertaking spot checks at various times throughout the week to include night duty and weekends.

Proposed Timescale: 20/04/2015

Theme:

Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Annual reviews of the quality and safety of care were not undertaken by the provider.

Action Required:

Under Regulation 23(d) you are required to: Ensure there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.

Please state the actions you have taken or are planning to take:

The Registered Provider will undertake an annual review of the quality and safety of care and this will be forwarded to the Authority.

Proposed Timescale: 31/07/2015

Outcome 03: Information for residents

Theme:

Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The residents' guide was not readily available to residents or their families. It was not included with all the other brochures on the information stand in the lobby.

Action Required:

Under Regulation 20(1) you are required to: Prepare and make available to residents a guide in respect of the designated centre.

Please state the actions you have taken or are planning to take:

The Registered Provider will ensure that the residents guide will be made available to residents and their families.

Proposed Timescale: 20/04/2015

Outcome 05: Documentation to be kept at a designated centre

Theme:

Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Details of the cause of death when established was absent from the directory

Action Required:

Under Regulation 19(3) you are required to: Ensure the directory includes the information specified in paragraph (3) of Schedule 3.

Please state the actions you have taken or are planning to take:

The Registered Provider will put in place a system to ensure that the cause of death will be included on the directory of residents.

Proposed Timescale: 20/04/2015

Outcome 07: Safeguarding and Safety

Theme:

Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Further work is required in exploring alternative options prior to using a restraint measures to promote a restraint free environment in line with the national policy.

Action Required:

Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

Please state the actions you have taken or are planning to take:

The registered provider will put in place a system whereby all alternative options will be explored and clearly documented prior to the use of any form of restraint.

Proposed Timescale: 30/04/2015

Theme:

Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement

in the following respect:

All staff had not received training in behaviours that challenge to ensure they have up to date knowledge and skills to respond appropriately.

Action Required:

Under Regulation 07(1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

Please state the actions you have taken or are planning to take:

The Person in Charge will ensure that all staff receives training in the Prevention and Management of Challenging Behaviour.

Proposed Timescale: 28/04/2015

Outcome 08: Health and Safety and Risk Management

Theme:

Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The fire alarm was not activated apart from the quarterly service to ensure it was operational and automatic doors closers were in good working order.

Action Required:

Under Regulation 28(1)(c)(iii) you are required to: Make adequate arrangements for testing fire equipment.

Please state the actions you have taken or are planning to take:

The Registered Provider will ensure that the fire alarm is activated on the 4th Thursday of each month, this will include checking of Automatic doors.

Proposed Timescale: 23/04/2015

Theme:

Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Only one fire drill practice apart from annual fire training has been completed and all staff have not had an opportunity to actively participate in a fire drill practice in addition to their annual training.

Action Required:

Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the

designated centre and residents are aware of the procedure to be followed in the case of fire.

Please state the actions you have taken or are planning to take:

The Registered Provider will ensure that all staff receive the mandatory fire training. Fire Training scheduled for 28/09/2015. Regular fire drills will be carried out at the centre to ensure staff and residents are aware of the procedure to be followed .Fire Drill will be carried out on a three monthly basis and recorded

Proposed Timescale: 23/04/2015

Outcome 09: Medication Management

Theme:

Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

A specific medication error reporting form is not available to guide staff on capturing all relevant details of medication error incidents with prompts to guide in appropriate responsive action.

Action Required:

Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

Please state the actions you have taken or are planning to take:

The Registered Provider has put in place a specific form for reporting Medication errors. Form attached

Proposed Timescale: 20/04/2015

Outcome 11: Health and Social Care Needs

Theme:

Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Evidence of consultation was not personalised to each resident's plan of care to reflect the individual care being delivered.

Action Required:

Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's

family.

Please state the actions you have taken or are planning to take:

The Person in Charge will ensure that the resident and/or the NOK will be involved in all formal review of Care Plans, either by consultation in the Centre or by telephone

Proposed Timescale: 20/04/2015

Theme:

Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Care plans for residents with dementia or cognitive impairment and behaviours that challenge required review to ensure they are more person centred.

Action Required:

Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).

Please state the actions you have taken or are planning to take:

The Registered Provider will ensure that care plans for those residents who have dementia or are cognitively impaired will be more person centred. Care Plans of our residents with a diagnosis of Dementia will be reviewed

Proposed Timescale: 20/04/2015

Theme:

Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

One resident receiving analgesia did not have a plan of care for pain management in place.

Action Required:

Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).

Please state the actions you have taken or are planning to take:

The Registered Provider will ensure that any resident receiving analgesia will have a care plan for pain management.

Proposed Timescale: 20/04/2015

Outcome 12: Safe and Suitable Premises

Theme:

Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The layout and configuration of the bedrooms did not assure the privacy of each resident. The provider at the time of this inspection did not have in place a plan to reconfigure multiple occupancy bedroom accommodation.

Action Required:

Under Regulation 17(1) you are required to: Ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.

Please state the actions you have taken or are planning to take:

The Registered Provider is currently working closely with colleagues from the estates department on plans for an extension and full refurbishment of this centre. The extension will consist of all single bedrooms and the existing area will be refurbished. The existing 4 bedded cubicles will be reduced to 2 bedded cubicles and will each have ensuite facilities. Design brief is complete and when drawn up the plans will be forwarded to the authority.

Proposed Timescale: 31/12/2015

Outcome 14: End of Life Care

Theme:

Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Advance care planning regarding future healthcare interventions and personal choice in the event a resident became seriously ill and was unable to speak for themselves was not completed for all residents.

Action Required:

Under Regulation 13(1)(a) you are required to: Provide appropriate care and comfort to a resident approaching end of life, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned.

Please state the actions you have taken or are planning to take:

The Person In Charge will ensure that appropriate care and comfort will be provided to each resident approaching end of life The documentation will include their personal choices in the event of them becoming serious ill .This may also include consultation with members of their family.

Proposed Timescale: 31/05/2015

Theme:

Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

The system to records the DNR reviews requires clarity as the records were not always legible. The previous review date was crossed off on the form and a new date written alongside.

Action Required:

Under Regulation 13(1)(a) you are required to: Provide appropriate care and comfort to a resident approaching end of life, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned.

Please state the actions you have taken or are planning to take:

The Person In Charge will ensure that recording of DNR status on each resident will be legible. The form will address the physical, emotional, social, psychological and spiritual needs of the resident concerned. A new form will be completed for each review and date inserted

Proposed Timescale: 31/05/2015

Outcome 17: Residents' clothing and personal property and possessions

Theme:

Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

There was limited space to store an adequate amount of clothing for residents. Residents had a single hospital style wardrobe. In many of the residents' wardrobes some hangers contained multiple pieces of clothing. In some cases clothes were stored on the bottom of the wardrobe.

Action Required:

Under Regulation 12(c) you are required to: Provide adequate space for each resident to store and maintain his or her clothes and other personal possessions.

Please state the actions you have taken or are planning to take:

The Person In Charge will ensure that additional wardrobe space will be provided to any resident who requires additional space.

Proposed Timescale: 31/05/2015

Theme:

Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

All clothes were not marked to identify ownership.

Action Required:

Under Regulation 12(a) you are required to: Ensure that each resident uses and retains control over his or her clothes.

Please state the actions you have taken or are planning to take:

The Person in Charge will ensure that all items of clothing are individually marked unless otherwise requested by the resident.

Proposed Timescale: 30/04/2015